

1878

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Napley Green		d. STREET ADDRESS Napley Green	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie A. Brooks		4. DATE OF DEATH Month Day Year Feb. 26 1956	
5. SEX F.	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26 1885
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY housekeeping	
11. BIRTHPLACE (State or foreign country) Rock Hall, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benj. Hynson		14. MOTHER'S MAIDEN NAME Fannie Hinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 214-28-8459	
17. INFORMANT Mallie James Brooks, Rock Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 430.0 DUE TO Coronary Thrombosis (b) Atherosclerotic heart disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH Immediate years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1952, to Feb. 26, 1956, that I last saw the deceased alive on Feb. 18, 1956, and that death occurred at 10 P.M. from the causes and on the date stated above. DATE SIGNED ACTUAL SIGNATURE Willard F. Smith M.D. Rock Hall, Md. PHYSICIAN'S NAME (Type) Willard F. Smith Rock Hall, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 29/56	
22c. NAME OF CEMETERY OR CREMATORY Sharptown Cemetery		22d. LOCATION (City, town, or county) (State) Rock Hall, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.		24a. REC'D BY REGISTRAR DATE Feb. 29/56	
24b. REGISTRAR'S SIGNATURE Wood Binger			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 5 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01862

1879 CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rock Hall</u>		<u>life</u>		TOWN <u>Rock Hall</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u>		(Middle) <u>B.</u>		(Last) <u>Crouch</u>		(Month) <u>Feb.</u> (Day) <u>9</u> (Year) <u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Fem.</u>	<u>White</u>	<u>Widowed</u>	<u>April 30, 1882</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Hodges</u>				<u>Fannie Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>none</u>		<u>Mrs. Tillie E Crouch--Rock Hall, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio Vascular. Coronary disease</u>						<u>Unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio sclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Circumstances of death?</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 1953, to <u>Feb 9</u> , 1956, that I last saw the deceased alive on <u>Feb 8</u> , 1956, and that death occurred at <u>3:44</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Robert E. Nitch</u>				ADDRESS (Street, city, town, state) <u>Rock Hall</u>		DATE SIGNED <u>Feb 10-56</u>	
23. BURIAL, CREMATION, REMOVAL, (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 11</u>		<u>Wesley Chapel</u>		<u>Rock Hall, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb 10/56</u>		<u>S. Elwood Benge</u>		<u>Edgar L. Rane</u>		<u>Church Hill, Md.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

DATE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. 1

FEB 16 1956

RECEIVED

1880

01863

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 200

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Kent	MARYLAND	STATE Md.	COUNTY Kent
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR	TOWN Millington
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highway west of Millington		STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED:		(First)		(Middle)		(Last)		4. DATE OF DEATH		(Month)		(Day)		(Year)	
(Type or Print)		John		Earl		Godwin		Feb.		12		19		56	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:		9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
male	white	Div.		Feb. 15, 1892		63 yrs.		Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:				11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Farm labor				Farm				Md.				U. S. A.			
13. FATHER'S NAME:								14. MOTHER'S MAIDEN NAME:							
Thomas Godwin								Emma Whittington							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.:				17. INFORMANT & ADDRESS:							
				217-30-8609				John Godwin - Maryland, Del.							

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause		Decapitation - To level of base of skull & complete excruciation of brain.		None	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO			
(c)					

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
none			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY street)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 2 12 56 2 AM.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		21f. HOW DID INJURY OCCUR Walking home & struck by vehicle	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE **Robert W. Farr** Robert W. Farr, M. D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **2/13/56**
 DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
Burial		2/14/56		Millington Cem.		Millington Kent Md.			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
2/13/56		Edward Fellows		Edward Fellows		Millington Md			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

FEB 20 1956

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1881 **CERTIFICATE OF DEATH**

01864

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		STATE <u>Maryland</u>		COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Worton</u>		<u>14 Yrs.</u>		TOWN <u>Worton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Andelot Farms</u>				STREET ADDRESS (If rural give location) <u>Andelot Farms</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>SUSIE HOLDSON</u>				<u>Feb. 12 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F.</u>	<u>W.</u>	<u>Single</u>	<u>July 4, 1881</u>	<u>74</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>laborer</u>		<u>housekeeping</u>		<u>Kent Co. Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Holdson</u>				<u>Frances Elizabeth Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Mrs. Frank Holdson 2519 Smith Ave. Balto. 30, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199.9 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Probable Carcinomatosis (Primary site unknown)</u>						<u>22 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>none</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>None</u>		<u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 20, 1956</u>, to <u>Feb. 12, 1956</u>, that I last saw the deceased alive on <u>Feb. 12, 1956</u>, and that death occurred at <u>12:30A</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Robert W. Farr, M.D.</u>				<u>2/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/14/56</u>		<u>Union Cemetery</u>		<u>Worton, Kent Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE Feb. 15-1956</u>		<u>Clara L. Barnes</u>		<u>Marvin V. Williams, Chestertown, Md.</u>			

CERTIFICATE OF DEATH

Form No. 10-1936

For use by the Registrar of the County or City

MARYLAND
JANUARY 1, 1937
BALTIMORE

BUREAU V. S.

FEB 20 1936

RECEIVED

INSTRUCTIONS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01865

1882

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		STATE <u>Maryland</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
TOWN <u>Rock Hall</u>		<u>life</u>		STREET ADDRESS		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Edsville</u>				STREET ADDRESS <u>Edsville</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>WILLIAM T. HOPKINS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 8 19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 9, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Lloyd Hopkins-RockHall, Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u>				<u>20 minutes</u>			
IMMEDIATE CAUSE (A) <u>Probable coronary thrombosis -</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-8, 19 56</u> to <u>2-8, 19 56</u> , that I last saw the deceased alive on <u>2-8, 19 56</u> , and that death occurred at <u>9:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Jan</u> M.D.				DATE SIGNED <u>2-10-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Sharptown Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rock Hall, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>S. Woodward Burgess</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams, Chestertown, Md.</u>		ADDRESS	
DATE <u>2/11/56</u>							

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	

BUREAU V. S.

FEB 16 1956

RECEIVED

Reg. Dist. No. 200

1

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>KENT</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>KENT</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GALENA</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GALENA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>PALMER KEENE HORSEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 9 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 1 1892</u>
9. AGE last birthday <u>64</u> yrs.		10. AGE last birthday (If UNDER 1 YEAR) (If UNDER 24 HRS.) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTER</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THOMAS H. HORSEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. RASIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>MRS. AUDREY B. HORSEY, GALENA, MD.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>6 mmo</u>	
IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusive</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Coronary Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>---</u>			
DUE TO (C) <u>---</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>---</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>---</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>Feb 1</u> , 19 <u>49</u> , to <u>Feb 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>56</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>H. H. Hunsicker</u>		ADDRESS (Street, city, town, state) <u>Willington Md</u>	
DATE SIGNED <u>2/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB. 11 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>SHREWSBURY CEM.</u>		LOCATION (City, town, or county) (State) <u>RURAL KENNEDYVILLE MD.</u>	
24. REC'D BY REGISTRAR <u>E. Elizabeth J. Muehl</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward T. Hunsicker</u>	
DATE <u>7/1/56</u>		ADDRESS <u>Willington Md</u>	



1872

CERTIFICATE OF DEATH

Reg. Dist. No.

2021

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7 Chestertown				c. LENGTH OF STAY IN 1b I day			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall (lifetime) X				d. STREET ADDRESS Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) Kent & Queen Anne Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last NATHANIEL HYNSON				4. DATE OF DEATH Month Day Year Jul 18 1956			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1903	
9. AGE (in years last birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Kent Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Hynson				14. MOTHER'S MAIDEN NAME Xxxxa, Artha Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 214-12-6724		17. INFORMANT Address Letitia Hynson Rock Hall, d. ... I	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia</u> 604X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable urinary lithiasis +</u> DUE TO <u>renal infection</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2-17, 1956 to 2-18, 1956 that I last saw the deceased alive on 2-18, 1956, and that death occurred at 9:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED R. W. Farr M.D. Chestertown, Md 2-18-56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Robert W. Farr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE OF REMOVAL (Specify) Feb. 21 1956		22c. NAME OF CEMETERY OR CREMATORY Sharptown		22d. LOCATION (City, town, or county) (State) near - Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown		24a. REC'D BY REGISTRAR DATE Feb 20-1956	
				24b. REGISTRAR'S SIGNATURE Clara S. Barnes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

200

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN ON HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01868

1884 CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rock Hall</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rock Hall R.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Lulu Catherine Kucher</u>				4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>28</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 4 - 1903</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Otto Lassen</u>				14. MOTHER'S MAIDEN NAME <u>Agusta Walter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>217-36-0757</u>		17. INFORMANT & ADDRESS <u>Trudy Kucher Rock Hall</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>12 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac enlargement, emphysema, marked</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Kyphosis of spine (probably due to Pott's disease of spine as child)</u>							
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1, 1953</u> , to <u>Feb. 28, 1956</u> , that I last saw the deceased alive on <u>Feb. 28, 1956</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Freeland F. Smith</u>				ADDRESS (Street, city, town, state) <u>Rock Hall, Md.</u>		DATE SIGNED <u>3/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>Chester</u>		LOCATION (City, town, or county) (State) <u>Chesdutton Md</u>	
24. REC'D BY REGISTRAR DATE <u>3/2/56</u>		REGISTRAR'S SIGNATURE <u>S. E. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01869

1873 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Kent</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Chestertown</u>	<u>1 day</u>	TOWN <u>Rock Hall Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent & Queen Anne General</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>CLADYS ESTELLE LAMBERT</u>		<u>2 16 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 2, 1897</u>
9. AGE last birthday <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Owen Donnelly</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Wrie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS <u>George E. Lambert, Rock Hall Md</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary insufficiency - acute</u>		<u>1 hour</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Probable coronary atherosclerosis - unknown</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I signed the deceased from <u>head and inspection</u> , 19....., that I last saw the deceased <u>live on 2-16</u> , 19....., and that death occurred at <u>2:15</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Deetha Tarn</u>		DATE SIGNED <u>2-16-56</u>	
ADDRESS (Street, city, town, state) <u>Chestertown, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
DATE THEREOF <u>Feb. 19</u>		REGISTRAR'S SIGNATURE <u>Charles E. Barlow</u>	
NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar E. Lane</u>	
LOCATION (City, town, or county) <u>Rock Hall</u>		ADDRESS <u>Chapel Hill Md.</u>	
24. DATE <u>Feb. 20 - 1956</u>			

STANDARD

1950

1950

1874

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.				d. STREET ADDRESS Rock Hall			
3. NAME OF DECEASED (Type or print) SUSTE E. LEARY				4. DATE OF DEATH 2/26/56 19 56			
5. SEX F...		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH March, 15, 1912		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac L. Leary				14. MOTHER'S MAIDEN NAME Virginia Maslin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-01-6023			
				17. INFORMANT Wm. E. Leary Address Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9442 (b) Fracture, lft Hip. Open Reduction (c) Fracture, lft Hip. Open Reduction							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture, lft Hip. Open Reduction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 2-13-1956 to 2-26-1956 , that I last saw the deceased alive on 2-26-1956 , and that death occurred at 3:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. J. Leary				M.D. CHESTERTOWN, Md			
PHYSICIAN'S NAME (Type) Arthur T. Leary				Chestertown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/56		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Class J. Barnes	
				DATE 2-1-1956		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1956

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1885

CERTIFICATE OF DEATH

Reg. Dist. No. *202*

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Highway between Worton & Syneck, Md.</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <i>RFD (Fairlee)</i>		
3. NAME OF DECEASED (Type or print) <i>Mattie L. Meredith</i>			4. DATE OF DEATH Month <i>2</i> Day <i>21</i> Year <i>1956</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-20-18</i>		9. AGE (In years last birthday) <i>38</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Talbot Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>James L. Cummings</i>		
14. MOTHER'S MAIDEN NAME <i>Lydia Marshall</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>110</i> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <i>216-10-3558</i>			17. INFORMANT <i>M. C. Meredith</i> Address <i>Chestertown, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture cervical vertebra (approx C4-6)</i> <i>80-44</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <i>None</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I on Page 4 of Form 18-1) <i>Ran off road about 1/2 mile 2/21/56 & was thrown out of car when it turned over several times.</i>			
20c. TIME OF INJURY Month <i>2</i> Day <i>21</i> Year <i>1956</i> Hour <i>12-2</i> a. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) <i>New Worton</i>	(County) <i>Kent</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>2-21</i> , 1956, to <i>Feb 21</i> , 1956, and that death occurred at <i>Mr. from the causes and on the date stated above.</i> ADDRESS (Street, city or town, state) <i>Chestertown, Md.</i> DATE SIGNED <i>Feb. 1, 1956</i>					
ACTUAL SIGNATURE <i>Robert W. Farr</i> M.D. <i>Chestertown, Md.</i>					
PHYSICIAN'S NAME (Type) <i>Robert W. Farr, M. D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/23/1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Chester Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Chestertown, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Willis Wells</i>		ADDRESS <i>Chestertown, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>2-28-56</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Barnes</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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1886

CERTIFICATE OF DEATH

01872

Reg. Dist. No. 200

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Galena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Galena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>P.</u> Last <u>RILEY</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years lost birthday) <u>Approx. 72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>usa</u>							
13. FATHER'S NAME <u>Robert Peaker</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Kerry Riley</u> Address <u>Galena md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 y. or</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>May 1950</u> , 19 <u> </u> to <u>Feb 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>55</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>2/25/56</u>							
ACTUAL SIGNATURE <u>H. H. Hamilton</u>				M.D. <u>Wilmington</u>			
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Feb 26/1956</u>		<u>Christ Hill Cem</u>		<u>Rural Galena md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Villous</u>				ADDRESS <u>Wilmington</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth Mulford</u>	

BUREAU V. S.

MAR 2

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1875
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01873
Reg. Dist.

No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Id</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		LENGTH OF STAY (in this place) <u>11</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>High St.</u>				STREET ADDRESS (If rural, give location) <u>High St.</u>			
3. NAME OF DECEASED: (First) <u>Joseph</u> (Middle) <u>ary</u> (Last) <u>SCHAUBER</u>				4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Dec. 23, 1947</u>		9. AGE last birthday: <u>8</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Joseph Schaubert</u>				14. MOTHER'S MAIDEN NAME: <u>Mary George</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No: <u>none</u>		17. INFORMANT & ADDRESS: <u>other Mary J. Schaubert Chestertown Maryland</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Due to</u>		<u>Suffocation</u>		<u>a few minutes</u>	
Antecedent cause(s) (b) <u>Due to</u>		<u>Head & neck were caught between gears elevator landing and elevator</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>from elevator</u>		21c. (City or town) (County) (State) <u>Chestertown Kent Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 5 1956 4:30 PM</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>was playing on</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.					
SIGNATURE <u>Rbert W. Farn</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>		DATE SIGNED <u>Feb 5 - 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>		DATE THEREOF <u>2/8 / 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Clester Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>		24. FUNERAL DIRECTOR <u>G. Wells Wells</u>		ADDRESS <u>Chestertown Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 6 - 1956</u>		REGISTRAR'S SIGNATURE <u>Cara S. Barnes</u>			



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

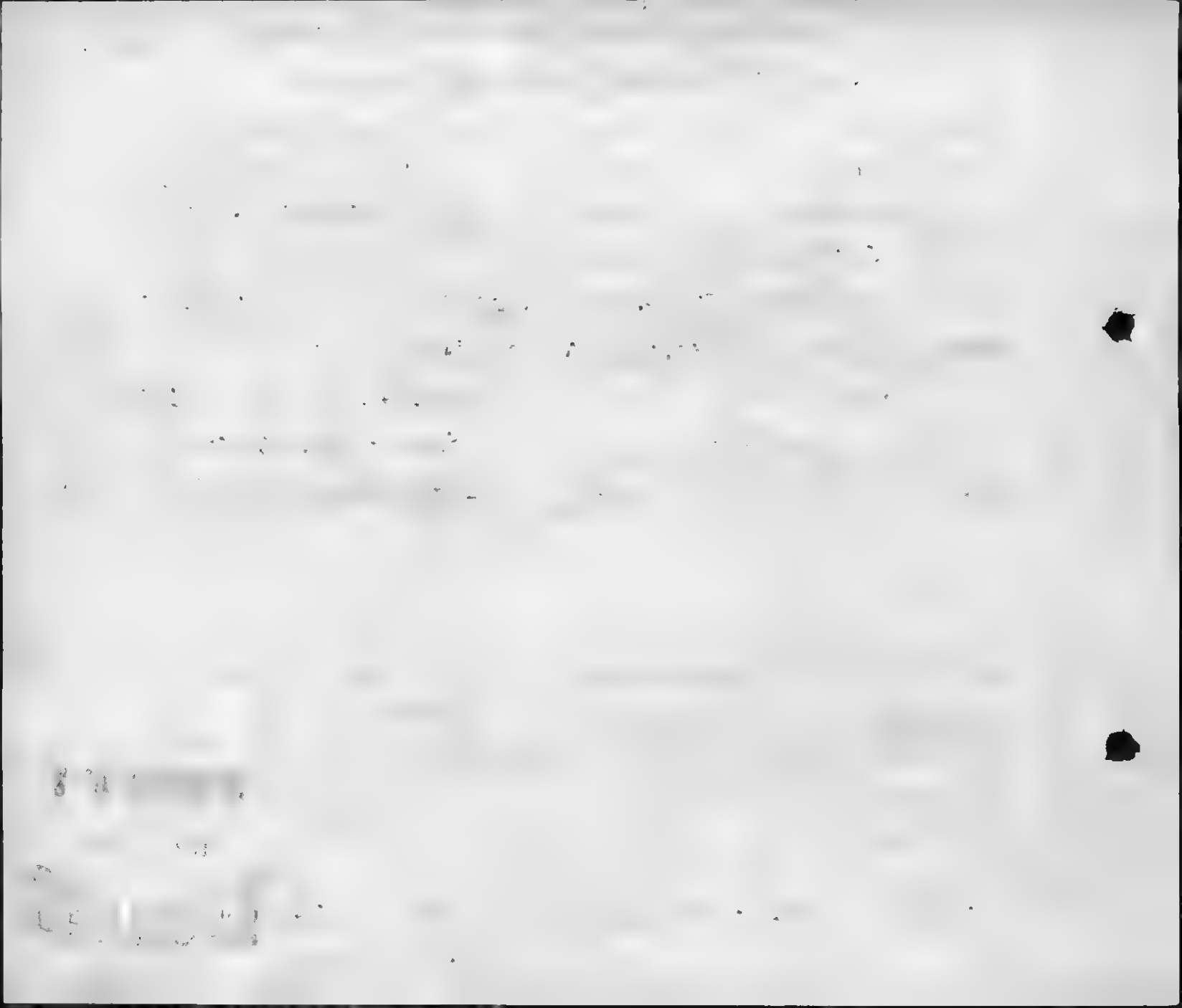
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01874

1887 CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>KENT</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FAIRLEE</u>		<u>6 MOS.</u>		TOWN <u>KENNEDYVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>STRONG NURSING HOME</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>SARAH ELIZABETH SCOTTEN</u>				(Month) (Day) (Year) <u>FEB. 6 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>NOV. 29, 1865</u>	<u>90</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>NONE</u>		<u>—</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN SCOTTEN</u>				<u>SARAH GREENWOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>ETHEL GREENWOOD STILL POND, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>PNEUMONIA - BRONCHIAL</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Stroke</u>						<u>6 or 7 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>D</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>2-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-6</u> , 19 <u>56</u> , and that death occurred at <u>2-6</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>R. L. Stewart</u>		M.D.		ADDRESS (Street, city, town, state) <u>Chestertown, Md</u>		DATE SIGNED <u>2/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB. 9, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>GALENA CEMETERY</u>		LOCATION (City, town, or county) <u>GALENA, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>		ADDRESS <u>STILL POND, MD.</u>	
DATE <u>2/7/56</u>							



1888

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>id.</u> b. COUNTY <u>kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. LENGTH OF STAY IN 1b <u>adult Life</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>rural (Reese's Corner)</u>				d. STREET ADDRESS <u>rural (Reese's Corner)</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Olan</u> First <u>David</u> Middle <u>Simpkins</u> Last				4. DATE OF DEATH <u>Feb. 26, 1956</u> Month <u>26</u> Day <u>19</u> Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 7, 1895</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Hart Simpkins</u>				14. MOTHER'S MAIDEN NAME <u>Queen Victoria Baxter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-36-0911</u>		17. INFORMANT <u>Franklin Simpkins</u>		Address <u>Rock Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia & acidosis</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of bladder</u> DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>about 2 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Dec. 1, 1955</u> to <u>Feb. 26, 1956</u> , that I last saw the deceased alive on <u>Feb. 26, 1956</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				ADDRESS (Street, City or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>Feb. 27, 56</u>			
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>Feb. 29, 1956</u>		<u>Chester Cemetery</u>		<u>Chestertown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wallis Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Feb 29/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>S. Elwood Binger</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 2 1900

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01876

1876 CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		STATE <u>Maryland</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
CITY OR TOWN <u>Chestertown</u>		LENGTH OF STAY (In this place) <u>3 years</u>		STREET ADDRESS <u>222 Washington Avenue</u>		STREET ADDRESS (If rural give location) <u>222 Washington Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY</u> <u>Edith</u> <u>Thomey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February</u> <u>9</u> <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 21, 1890</u>	
9. AGE last birthday <u>65</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered nurse</u>				10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>			
13. FATHER'S NAME <u>JAMES Dunbracco</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Hendricks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-01-4530 A</u>		17. INFORMANT & ADDRESS <u>Mrs. Sue W. Snome, Chestertown, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <u>Metastatic carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of colon</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>JUNE 1953</u>		19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA of colon 2 Metastases</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August</u>, 19<u>55</u>, to <u>Feb 9</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Feb 7</u>, 19<u>56</u>, and that death occurred at <u>1:55</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Edith Thomey</u>				ADDRESS (Street, city, town, state) <u>Chestertown, Md.</u>		DATE SIGNED <u>2-9-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. II, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u>	
24. REC'D BY REGISTRAR <u>Feb. 11-1956</u>		REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown Maryland</u>	

DEATH CERTIFICATE

BUREAU V. M.

FEB 14 1956

RECEIVED

1877 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown 37</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00 201 S. Water Street</u>				d. STREET ADDRESS <u>201 S. Water Street</u>			
3. NAME OF DECEASED (Type or print) <u>MARIE</u> First <u>Josephine</u> Middle <u>Grinter</u> Last <u>Whitsett</u>				4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 5, 1903</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Kansas City Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Eugene F. Grinter</u>				14. MOTHER'S MAIDEN NAME <u>Wendy Pratt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u> </u>		17. INFORMANT <u>A.F. Whitsett, Chestertown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of breasts</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 mos.</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Dec. 15, 1956</u> , to <u>Feb. 19, 1956</u> , that I last saw the deceased alive on <u>2-18</u> , 19 <u>56</u> , and that death occurred at <u>7:00 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.C. Dick</u>				DATE SIGNED <u>2-19-56</u>			
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>				ADDRESS <u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Saint Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>nr. - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Willis Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-21-1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Claude L. Barnes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 28 1956

BUREAU V. S.

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS